WOODS CHARTER SCHOOL

Student Agreement For Self Carried Medications

Without Staff Supervision or Assistance

Student's Name ____________________________________ **Grade** _______

TO BE COMPLETED BY PHYSICIAN:

The student must have medication(s) listed below during the school day or at school sponsored events in order to function at school. **Adult supervision is not needed.** The student has been instructed in the treatment plan, self administration of the listed medication(s) and has demonstrated the skill level necessary to self administer.

Medication _________________________ **Dose**_______________ **Route** _______________

Time __________ **Frequency** _______________ **For treatment of :** __________________

Possible side effects: ____

Special Instructions: ____

____ ______________________

Printed Physician's Name Tel.

____ ______________________

Physician's Signature Date

TO BE COMPLETED BY PARENT:

I request and give permission for my my child to carry and give the medication(s) listed above during the school day, and at school sponsored activities or while in transit to and from school. **Adult supervision is not needed.**

I UNDERSTAND THAT:

1. My child has demonstrated the skill level necessary to use the self-administered medications prescribed by his / her health care provider.
2. My child will be subject to **disciplinary action** if medication(s) is used in any other manner other than that prescribed.
3. I shall provide the school, coach, or before/after school personnel with any changes to medical condition / physician's orders, prescription changes, or change in contact information.
4. **I shall provide to the school, coach, or before / after school personnel back-up medication (in addition to what student will carry.**
5. **In the event my child is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector ordered by the physician, a trained school staff member may administer the Epinephrine Auto injector and call 911.**
6. **In the event that my diabetic child loses consciousness and requires immediate glucagon injection ordered by physician, a trained school staff member may administer the injection.**

____ ______________________

Parent Signature Date

TO BE COMPLETED BY STUDENT AT SCHOOL:

- I have demonstrated the use of my medication to the school staff.
- I plan to keep my medication and equipment with me at school
- I will use **only** as prescribed by my doctor.
- I will notify a school staff member if I am having more difficulty than usual with my health condition.

____ __________________
Student Signature Date

TO BE COMPLETED BY TRAINED DESIGNATED SCHOOL STAFF:

I have observed the student indicated above verbalize and demonstrate the skill level necessary to use the medication(s) prescribed by the above physician.

1. ____ __________________

2. ____ __________________

Signatures of Designated School Staff Date